Healthpoint

Information from the Division of Health Care Finance and Policy

MENTAL HEALTH PARITY: WHAT WILL IT BRING MASSACHUSETTS?

In December of 1999, the US Surgeon General issued its first ever report on mental health, emphasizing the need for comprehensive behavioral health care coverage. The report estimates that one in five American adults endure a diagnosable mental illness in any given year, but less than a third of them seeks treatment. It also estimates that mental illness costs society about $200 billion annually in direct and indirect expenses.[1] Similarly, the Massachusetts Department of Mental Health reports that 15.22% of adult residents have a diagnosable mental illness in any given year.[2] This belated public attention to mental illness and its societal impact has lead researchers and legislators to scrutinize the comprehensiveness of behavioral health benefits, including the 1996 federal parity legislation.

While the objective of parity is to ensure that payers provide the same standard level of benefits for behavioral health and substance abuse as for physical health, the law has many shortcomings. It neglects to mandate provisions for substance abuse treatment, exempts small firms, and fails to require plans without mental health coverage to offer such benefits. Concurrently, primary care physicians (PCPs), pharmaceuticals, and managed care carve-outs are each playing an increasing role in the treatment of mental illness, leading us to ask: How relevant is parity now? With the recent enactment of full parity legislation in Massachusetts, this *Healthpoint* explores the impact and relevancy of the new law as it affects payers, providers and residents of the Commonwealth.

Mental Health Legislation

The 1996 Federal Mental Health Parity Act mandates that all employers offer equivalent annual and lifetime monetary coverage for behavioral and physical health needs. A lesser-known "sunset" provision, included to protect employers from unanticipated long term costs, automatically terminates the federal law on September 30, 2001.[3] With states left to fill in the gaps, Massachusetts passed one of the most comprehensive mental health parity laws in May 2000.

Who Is Covered and Who Is Exempt?

The Massachusetts mandate requires complete compliance for all members of HMOs, employer group plans and non-group individual plans by January 1, 2001.

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Smaller employers must comply by January 1, 2002. Under the 1974 Employee Retirement Income Security Act (ERISA), states cannot regulate employer-provider health plans, exempting most self-insured employers, many of whom voluntarily comply with state mandates. While MassHealth (Medicaid) clients and state prisoners are also exempt from state mandates, Medicaid has historically provided comprehensive mental health and substance abuse benefits.

What Is Covered?

The Massachusetts mandate requires employers to provide full parity for "biologically-based" brain disorders classified in the Diagnostic and Statistical Manual-IV (DSM-IV), such as schizophrenia and major depression. It provides full parity for substance abuse only when co-occurring with a mental illness. It requires insurers to maintain the 60 day inpatient care minimum mandated under current law and to triple the number of outpatient visits to 24 for all non-biologically based psychiatric disorders in the DSM-IV. Mental health assessments and visits made for monitoring medications are covered in full and are not considered part of the outpatient visit allotment. Furthermore, the mandate establishes unlimited outpatient visits for children under age 19, if their disorder is even at risk of interfering with normal cognitive and social development.

From Paper to Practice: Will Parity Have an Impact?

Despite the comprehensive nature of the Massachusetts parity law, two divergent trends in mental health services could impact its intended effects.

Roughly 50% of depressed patients are treated by primary care physicians (PCPs), while only 20-30% of these patients seek concurrent treatment with a behavioral health specialist.[4] The prominent role of PCPs in treating mental illness is troublesome. One concern is the difficulty in accurately diagnosing less acute mental disorders and symptoms of substance abuse. A study of HMO primary care patients treated for depression found that PCPs accurately diagnosed only 50% of all depression-related cases.[5] PCPs are also prescribing about 66% of all psychotropic drugs[6] and one study of a national managed care organization's antidepressant utilization patterns indicates that PCPs prescribe 77% of all antidepressants, with only 42% of these prescriptions based on a documented primary or secondary diagnosis of depression.[7]

It is unknown whether the increased role of PCPs in the treatment of mental disease is due to patient preference (less stigma, more familiarity), limited availability of specialists, capitation incentives or other reasons, yet it almost certainly impacts the quality of care (especially vis a vis psychotropic drug prescriptions). It should be noted that in Massachusetts, HMOs generally do not require referrals for mental health services and it is not known whether the national trend toward increased PCP involvement in treating mental illness occurs here where specialists are plentiful. To discourage this trend from materializing here, purchasers could adopt the Group Insurance Commission (the state employee and retiree benefits purchaser and manager) policy, which only covers mental health services, including psychotropic drug prescriptions, when rendered by a licensed behavioral health specialist. Since visits to a PCP whether for mental or physical illness are unlikely to be limited, parity here appears moot, but a concern over quality is not.

At the same time, the past decade saw a significant increase in managed care carve-outs, a separate vendor or Managed Behavioral Health Organization (MBHO) that provides mental health and substance abuse services. In contrast to concerns surrounding PCP care, carve-outs provide mental health services from a network of licensed behavioral health specialists in a concerted effort to pro-

vide quality, specialized care. MBHOs could indirectly thwart the quality of care strived for in the parity legislation, however, through lower reimbursement rates, possibly resulting in fewer experienced specialists participating in the network. Harvard Pilgrim Health Care, for example, recently contracted with MBHO Value Options to manage its behavioral health services, paying them a capitated monthly per-member fee. Value Options subsequently decreased reimbursement rates for psychiatrists and psychologists, but increased payments for social workers and other Masters level professionals, and stated its intention to increase the use of group therapy.

While these modifications in service delivery may not have a deleterious effect on care, it will be important for managed care organizations (MCOs) to evaluate the carved-out services and monitor member satisfaction. MCOs must also be vigilant that the use of a capitated incentive system with for-profit MBHOs does not lead to inappropriate reductions in referrals, hospitalizations or lengths of treatment, thereby indirectly undermining parity by compromising quality.

Direct Costs of Parity

Several analyses on the costs of mental health coverage have been published. Despite estimated cost increases (ranging from 2-4%) under federal parity, the US General Accounting Office (GAO) reported that only 3% of employer respondents experienced an increase in overall health care costs due to parity compliance.[8] It is widely surmised that many employers simply substituted visit restrictions or increased copayments, deductibles, out-of-network charges and out-of-pocket contributions for the prohibited dollar cap. The cost impact of Massachusetts' parity law on premiums is projected to be similar if not lower than national estimates and significantly less than the projected individual premium increases by payers due to the large HMO penetration in the Commonwealth and anticipated cost-containment measures likely to be adopted by employers to offset parity-related expenses (see table above).[9]

An Actuarial Analysis of the Massachusetts Mental Health, Alcoholism and Chemical Dependency Parity Law

Payer Type	Percent Increase in Health Plan Premium Due to Comprehensive Parity	Total Mental Health and Substance Abuse Claims Costs Per Member Per Month (PMPM)
HMO	1.6%	$6.02
PPO and POS	2.5%	$8.09
Managed Indemnity	3.2%	$12.31
Fee-for-Service	3.9%	$15.26
Net Market Impact	1.0%	$1.41

Source: Coopers & Lybrand and the American Psychological Association

Indirect Costs of Parity

The cost of mental health coverage must be contrasted with the cost of non-treatment or substandard treatment. One analysis associated a $79 billion loss to the US economy in indirect costs, with the majority of these costs ($63 billion) attributed to lost productivity.[10] Mental illness has a low mortality rate, but if untreated, can severely impinge on one's productivity and health over a life span. Similarly, the World Health Organization's Global Burden of Disease study reported that five of the top ten leading causes of disability and premature mortality are psychiatric and addictive mental disorders, accounting for over 15% of the overall burden of disease from all health related causes.

When looking at the burden placed on Massachusetts specifically, the cost can be illustrated in part by reviewing the prevalence of mental health services sought through general acute hospitals. In 1999, seven percent of total acute hospital discharges in the Commonwealth had a primary diagnosis

of psychiatric or substance abuse, with the psychoses diagnosis (DRG 430) consistently ranking first or second in both percent of discharges and percent of charges among all acute hospitalizations.[11] The burden of such care is even more striking within the uninsured population, where 11.7% of patients using the Uncompensated Care Pool to finance their hospitalizations were admitted for mental disease and disorders, second only to problems with the circulatory system.[12]

What Can We Expect for the Future?

In 1999, President Clinton directed the Office of Personnel Management to achieve "full parity," including substance abuse in the Federal Employee Health Benefits Program (FEHBP) by 2001.[13] Both houses of the 106th Congress have introduced such legislation prohibiting numerical limits on inpatient and outpatient visits, repealing the 1996 exemption for employers who report an increase in their premiums greater than one percent and revoking the "sunset" provision.

By virtue of passing comprehensive parity legislation, Massachusetts is uniquely positioned as a pioneer for the mentally ill. Now, the Commonwealth must seize the opportunity to evaluate the impact of parity on payers, providers and patients by following the trends in costs, accessibility and utilization of mental health services. The actual success of parity will depend on its evolution from paper to practice.

Endnotes

1. *Mental Health: A Report of the Surgeon General;* and a National Association of Psychiatric Health Systems news release.
2. Massachusetts Department of Mental Health. *Fiscal Years 1999 & 2000: State Mental Health Plan*, p. 34, and "Facts about Mental Health."
3. Bazelon Center for Mental Health. "Parity Bills Introduced In Both Houses," April 30, 1999.
4. Way, Karen, Ph.D., et. al. "Antidepressant Utilization Patterns in a National Managed Care Organization." *Drug Benefit Trends.*
5. Ibid.
6. *Mental Health: A Report of the Surgeon General.*
7. Way, et. al.
8. GAO, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, May 2000, p. 5-6.
9. Bachman, Ronald E., FSA, MAAA. *An Actuarial Analysis of Mental Health, Alcoholism, and Chemical Dependency Parity and Other Options for Improved Coverages in the State of Massachusetts*, May/June 1998, p. 4.
10. *Mental Health: A Report of the Surgeon General.*
11. Massachusetts Division of Health Care Finance and Policy. 1999 hospital discharge data.
12. Massachusetts Division of Health Care Finance and Policy. *Report of the Special Commission on Uncompensated Care*, February 3, 1997.
13. *Business and Health.* "Parity, Paid Leave for Federal Workers." July 1999.

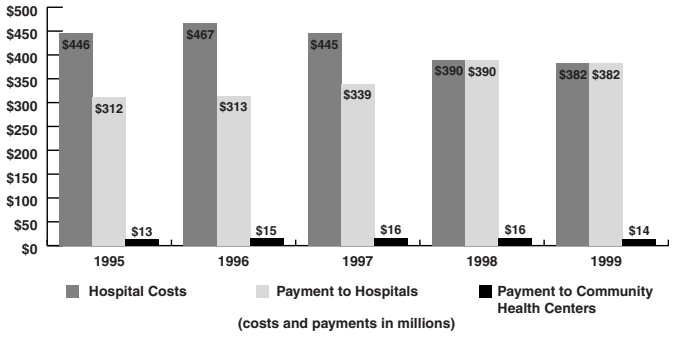
Did you know?

CHCs and Hospitals Are Paid Differently for Uncompensated Care

Since 1992, the Uncompensated Care Pool has paid community health centers (CHCs) for the uncompensated care they provide. Unlike hospitals, the Pool pays CHCs based on a standard fee schedule. Also unlike hospitals, CHC payments from the Pool are not reduced when there is a shortfall in Pool funds, therefore, there is no difference between allowable costs and payments for CHCs as there is for hospitals.

Beginning in 1998 the Pool was funded adequately to cover all charges to it. Prior to this time, uncompensated care charges were greater than the dollars available to fund such care, resulting in a shortfall.

Allowable Cost and Payment to Hospitals and CHCs for Uncompensated Care in Massachusetts (1995-1999)



Note: These numbers have not been adjusted for inflation.

Sources: Uncompensated Care Pool PFY99 Annual Report, March 2000 and "Community Health Center Payment Voucher Supplemental Form," Division of Health Care Finance and Policy

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